MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

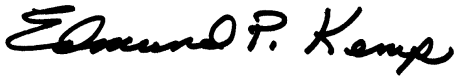
NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.



Director, Program Policy Division
Bureau of Medicaid Policy and Actuarial Services

Project Number:	0908-Eligibility	**Comments Due:**	April 1, 2009	**Proposed Effective Date:**	April 1, 2009

Mail Comments to: Bridget Heffron
Bureau of Medicaid Policy & Actuarial Services
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979

Telephone Number: (517)335-3526

Fax Number: (517) 241-8969
E-mail Address: heffronbr@michigan.gov

Policy Subject: Medicaid Eligibility Policy Updates

Affected Programs: SSI related MA programs (Extended Care, ADCare, etc)

Distribution: Medicaid Manual Holders

Policy Summary: Updating the procedures for an ex-parte Medicaid (MA) review when a mid-certification contact is being completed for an associated Food Assistance case; updating steps for the completion of a pre-paid funeral contract by the client and the funeral director; updating tentative identification of a disabled adult child (DAC); updating penalty amounts for divestment penalty calculations; updating addresss of Trust Unit; and adding limited liability corporations (LLC) to Asset policy (this is a new item).

The public comment phase of this policy is being conducted concurrently with final.

MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 09-14

Distribution: Medicaid (MA) Manual Holders

Issued: March 1, 2009

Subject: Medicaid Eligibility Policy Updates

Effective: April 1, 2009

Programs Affected: SSI-Related MA Programs (ADCare, Extended Care, etc.)

Changes to Medicaid Eligibility policy is as follows:

- Several procedures for determining MA eligibility have been updated to bring worker relief in the local offices. MA groups who also receive Food Assistance Program (FAP) benefits, which are assigned a 24-month benefit period, are permitted to use the FAP mid-certification contact information to complete a MA eligibility review.

- Contracts for pre-paid funerals are to be completed by the client and the funeral home before returning to the Department of Human Services (DHS) for certification of irrevocability.

- Information was added regarding treatment of limited liability corporations (LLC) relative to eligibility and divestment. This is new policy as there was no discussion of LLCs in previous policy.

- Information from the Social Security Administration has changed regarding the tentative identification of a Disabled Adult Child (DAC) beneficiary.

- As a maintenance measure, contact information for the Trust Unit and 2009 Cost of Living Adjustments (COLA) for divestment penalty calculations will be updated.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Bridget Heffron
MDCH/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: heffronbr@michigan.gov

If responding by e-mail, please include “April Policy Changes” in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Program Eligibility Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Acting Director
Medical Services Administration

RD-093, LTC Case Identification

MA Only

The LTC-application indicator (4574) on the RD-093 identifies MA LTC cases. The DHS-4574, Medicaid Application (Patient of Nursing Facility), is the appropriate application to use for the MA redetermination. The level of care code indicating long-term care is used to identify these cases.

RD-093, Deductible Case Identification

MA Only

The deductible indicator (#) identifies active deductible cases. This indicator will be printed when the eligibility status code for all members of an MA case is 07.

TMA REDETERMINATION REPORT

TMA Only

TMA cases appear on the RD-210 in the fourth month before TMA eligibility ends. The redetermination process must begin immediately and be completed sooner than for other cases so the family can have an opportunity to get TMA-Plus. You must complete all DHS actions at least 40 days before the end of the 12-month TMA eligibility period. See PEM 647 for details about when actions must be completed.

MID-CERTIFICATION CONTACT

FAP and MA except ALMB

FAP ~~and MA~~ Groups assigned a 24-month benefit period and FAP groups with earnings assigned a 12-month benefit period (as described in **PAM 115**) must have a mid-certification contact. The contact requirement is met by completion of a DHS-2240A, Mid-Certification Contact Notice for cases assigned a 24-month benefit period and by a DHS-1046, Semi-Annual Contact Report, for FAP cases with earnings assigned a 12-month benefit period. The form may be completed by the client or by the specialist (during a telephone call, home call or interview with the client).

MA groups who also receive FAP benefits assigned a 24-month benefit period are permitted to use the FAP mid-certification contact information to complete a MA eligibility review. The updated income and asset information should be used to complete a budget for the next 12-month benefit period.

FAP Cases due for mid-certification/semi-annual contact are listed on the RD-093 report. CIMS automatically generates a DHS-2240A for cases assigned a 24-month benefit period during the eleventh month of their benefit periods and a DHS-1046 the beginning of the fifth month for cases assigned a 12-month benefit period. Report RD-550, Food

A **non-guaranteed price contract** states clearly that the price of listed goods and services might fluctuate. Actual costs at delivery might be more or less than the amount in the contract fund.

A **revocable contract** can be terminated by the purchaser and the money refunded. The refund might be less than the contract's total value. A contract is revocable **unless** certified irrevocable.

For program eligibility purposes, an **irrevocable contract** means money in the contract fund, including interest or dividends, is permanently unavailable to the purchaser/beneficiary.

See "CONDITIONS TO CERTIFY CONTRACTS IRREVOCABLE" in this item.

OUT-OF-STATE FUNERAL CONTRACTS

DHS and DCH can certify as irrevocable a funeral contract with an out-of-state contract seller or funeral provider **only if** the seller **and** provider (if separate) are registered with the Michigan Department of Labor and Economic Growth. If they are, refer to "CONDITIONS TO CERTIFY CONTRACTS IRREVOCABLE" in this item.

A prepaid funeral contract with an **unregistered** out-of-state seller or provider is controlled by the other state's laws. The contract funds are unavailable **if** the contract is irrevocable under the other state's law.

Assist clients needing help to determine the status of out-of-state contracts. Inform them that revocable contracts with unregistered individuals may be reestablished using sellers/providers registered with the Michigan Department of Labor and Economic Growth.

Local Office Responsibilities

~~Give or send an DHS-8A, Irrevocable Funeral Agreement Certification, to clients who want to establish an irrevocable contract.~~ Tell the applicant/recipient in order to certify a funeral agreement as irrevocable they and their funeral director must complete an DHS 8-A (available on the web or through the funeral director) and return the completed form to the local office. Tell them they must:

- Complete Section I, **and**
- Have the contract seller complete Section II, **and**
- Give DHS a copy of the contract.

Forward the returned DHS-8A and contract to the **local office director or designee** for certification (completion of Section III). If a disapproval is necessary, it must be explained on that form.

A photocopy or facsimile (fax) of a DHS-8A is acceptable.

- Travel for a parent, relative, guardian or attendant who is accompanying a client who is a minor child.
- Travel for family members of clients who are children in an inpatient hospital treatment program, if the family members are part of a structured treatment or therapy program.
- Travel for one trip for examination and one trip per Medical Review Team (MRT) recommendation for clients claiming disability or blindness.
- Travel within or outside the normal service delivery area including borderland outstate travel (local offices have responsibility for defining normal service delivery area).

Meals and Lodging

- Overnight stays (including meals and lodging) for up to 5 consecutive nights for:
  - One parent or guardian of a child for any inpatient stay.
  - One client and, in addition, one parent of a child, spouse, guardian or attendant for outpatient treatment at U of M Hospital.

  See **"PRIOR AUTHORIZATION"** for stays beyond 5 days.

Exception: Meals and lodging may be authorized for one parent of a child at U of M MOTT Children's Pediatric Hospital for up to 14 days. See **"PRIOR AUTHORIZATION"** for stays beyond 14 days.

- Overnight stays if travel is 50 miles (one-way) or more from the client's home. DCH must prior authorize overnight stays when the distance is less than 50 miles.
- Meal allowance associated with long-term recovery housing for bone marrow transplant operations at U of M or Harper Hospital (amount determined by DCH) and prior authorized through the transplant coordinator. Lodging necessary prior to bone marrow transplant operation is to be paid.
- Meals for trips not involving overnight stays. Prior authorization is required from DCH. See "Essential Medical Transportation Rate Schedule"

Payment Authorization

Authorize payment for medical transportation beginning the month the client reported the need.

At application, do not authorize payment earlier than the MA begin date. If program eligibility is denied, only authorize payment for transportation to obtain medical evidence.

unless the client is enrolled in managed care. See **"CLIENTS IN MANAGED CARE"** for more information.

- Transportation for day treatment provided by a Community Mental Health Services Program (as part of its treatment package) for clients enrolled in the children's waiver.
- Emergency ambulance transportation.
- Transportation for recipients who receive dialysis treatment at dialysis centers that provide transportation.
- Long-term housing related to transplant operations.

PRIOR AUTHORIZATION

All prior authorization requests must be submitted before the service is provided and payment is made. Exceptions will only be granted for emergency situations or when extenuating circumstances exist and are clearly documented.

No exceptions will be made for requests submitted one month or more after the service is provided.

The following transportation expenses require prior authorization from DCH:

- All outstate travel that is non-borderland (see PAM 402).
- Overnight stays if within 50 miles from recipient's home (one way).
- Overnight stays beyond 5 days (14 days for U of M MOTT Children's Pediatric Hospital).
- Overnight stays or travel outside the normal service delivery area if expenses for two or more family members are included.
- Meals for trips not involving overnight stays. See exhibit 1"Essential Medical Transportation Rate Schedule"
- Special allowance when two or more attendants are medically necessary.
- Mileage and food costs for daily long-distance trips.
- Methadone treatment that extends beyond 18 months (DCH/CMH).

It is important that documentation include the **specific reason(s)** why the client requires special transportation. Attach the following to the DHS-54A:

- Client name.

regardless of the number of beneficiaries being transported, not for each beneficiary transported.

Note: A state vehicle may be used to transport clients. The local office fiscal unit completes the DHS-1309, Official Daily Travel Log. See the County Accounting Manual for details.

Bus Tickets

You are encouraged to have a supply of tickets, tokens, passes, etc. available for clients who wish to use a city bus or mass transit for medical transportation.

Special Allowances

All special allowances must be prior authorized by DCH before payment may be made and must be reviewed yearly. See "REVIEW" and "PRIOR AUTHORIZATION."

Do not authorize payment for a special allowance for transport in a private vehicle or van.

The special transportation allowance is:

- Medically necessary attendant - $10.00 per attendant per round trip when an attendant is medically necessary in addition to the driver of the specialized and non-emergency medical transport vehicle.

  See **"PRIOR AUTHORIZATION"** when two or more attendants are medically necessary.

  Note: Drivers of specialized and non-emergency transport vehicles are expected to assist the client. Authorize the above special allowance only if the client verifies that an attendant, in addition to the driver, is medically necessary to assist the client into and out of the building or that without such assistance it would be impossible or unsafe for client to enter and exit the building.

Parking Fees

Parking lot fees and tolls are reimbursable if verified with receipts.

Meals and Lodging

See Exhibit I, **"ESSENTIAL MEDICAL TRANSPORTATION RATE SCHEDULE"** for appropriate meal and lodging allowances. This includes rates for meals only when there is no overnight stay.

Reimburse volunteer services drivers (meals only) at the Volunteer Services rate while transporting MA clients. Local office guidelines apply.

Encourage lodging providers to bill the local office directly when overnight accommodations are authorized.

Reflect actual cost of lodging or meals when advance payments are made for less than the maximum table rates.

- The type of provider to furnish each service.

Care Management The agent is responsible for arranging for plan services to be provided.

APPROVED FOR THE WAIVER

Approved for the waiver means:

- The agent conducted the assessment, **and**
- The participant received, or expects to receive, supports coordination services from the agent with appropriate waiver services for at least 30 consecutive days.

Approval and Termination Dates

The agent determines the waiver approval date and termination date. The agent is responsible for advising the appropriate local DHS office of these dates.

The waiver automatically terminates when the patient enters an LTC facility. See PEM 547 for instructions.

DHS LOCAL OFFICE RESPONSIBILITIES

Local offices' primary responsibilities are doing initial asset assessments and determining MA eligibility for waiver patients.

Waiver Patient Defined

A waiver participant is a person whose month being tested is a waiver month.

Waiver Month Defined

A waiver month is a calendar month containing at least one day that the participant is (was) approved for the waiver. The agent determines the waiver approval date.

Note: For purposes of MA eligibility, a month remains a waiver month even if the waiver participant enters a LTC facility and/or hospital in the same calendar month. A waiver month does not become a L/H month (See PRG).

Eligibility

Special MA policies to use in the eligibility determination are:

- A waiver participant is a group of one even when he lives with his spouse (PEM 211).
- The Special MA Asset Rules in PEM 402 apply.
- MA divestment policy in PEM 405 applies to waiver participants.
- The extended-care category is available to waiver participants (PEM 164).
- Income must be at or below 300% of the SSI Federal Benefit Rate.

- The child is **not** already receiving MA.

Note: Do **not** wait for DCH to authorize MA when you are notified of the birth.

Input

DCH will authorize MA for the newborn as follows:

- Mother's program code is C, L or N: DCH will add the newborn to the mother's case.

Exception: DCH will open a program L case for the newborn when the mother is on program N with scope/coverage 2F or 2E. The mother will be the grantee.

- Mother's program code is B, E, O, P or Q: DCH will open a program code L case for the newborn using the mother as the grantee.

~~**Notification**~~

~~After authorizing MA, DCH will:~~

- ~~Send you a memo notifying you of the action, and~~
- ~~Send you screen copies of the accepted CIMS transactions for the case record, and~~
- ~~Notify the grantee of the need to apply for the child at DHS, and~~
- ~~Send the grantee an DHS-1171.~~

Local Office Responsibilities

You are responsible for taking appropriate action on DCH-authorized newborns when changes are reported (e.g., family moves, mother no longer meets the requirements in this item).

DCH will use~~is using~~a Father Status code 3 and the mother's race code on all newborns. Determine the correct father status and race for the newborn the next time the case is handled, but no later than the next redetermination. Correct these codes, if necessary.

SUPPORT REFERRALS

Refer a newborn to the support specialist if the child:

- Does **not** have a legal father, **or**
- Has an absent father.

Support referrals are a service for the mother and child. Cooperation is **not** a condition of eligibility for the newborn. However, it may be for the mother. See PEM 255.

Note: DAC RSDI is also called Childhood Disability Benefits (CDB).

3. The person is currently receiving DAC RSDI benefits.

   Note: When SSA employees say someone is a "DAC" they mean he receives DAC RSDI.

4. The MA eligibility factors in the following items must be met.

   - PEM 220, Residence.
   - PEM 221, Identity.
   - PEM 223, Social Security Numbers.
   - PEM 225, Citizenship/Alien Status.
   - PEM 255, Child Support.
   - PEM 256, Spousal/Parental Support.
   - PEM 257, Third Party Resource Liability.
   - PEM 265, Institutional Status.
   - PEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Groups Use fiscal and asset group policies for SSI-related groups in PEM 211.

Assets Countable assets **cannot** exceed the asset limit in PEM 400. Countable assets are determined based on the MA policies in PEM 400, 401 and 402.

Divestment Policy in PEM 405 applies.

Income Eligibility Income eligibility exists when net income does **not** exceed the special protected income level in RFT 245. Income eligibility **cannot** be established with a patient-pay amount or by meeting a deductible.

Determine countable income according to MA policies in PEM 500 and 530 **except** as explained in **"COUNTABLE RSDI"** below. Apply the deductions in PEM 541 to countable income to determine net income.

COUNTABLE RSDI Exclude all RSDI benefits for the person whose DAC eligibility is being determined.

For all other persons, countable RSDI is the person's gross RSDI for the month being tested. Gross RSDI means the amount before any deductions such as Medicare.

IDENTIFYING DACS ~~Assume a~~A person ~~is~~may be receiving DAC RSDI benefits if one of the following descriptions applies:

- He has been identified as a DAC by central office or an SSI letter (see Exhibit II) and his social security claim number suffix contains the letter C. The C may be followed by another letter or number (CA, CB, C1, etc.).
- He is more than 19 years 2 months old and his social security claim number suffix contains the letter C. The C may be followed by another letter or number (CA, CB, C1, etc.).
- He is age 18 or older, **not** a full-time student in elementary or secondary school and his social security claim number contains the letter C. The C may be followed by another letter or number (CA, CB, C1, etc.).

Note: When a person meets a bullet listed above you must request a screening for DAC eligibility from central office unless a determination has already been completed by central office. After you receive verification of DAC RSDI from central office you still need to determine all other factors for MA eligibility (income and asset etc., listed on page 1 of this item) are met. You should retain the copy of the verification from central office as you only need to verify DAC RSDI once.

VERIFICATION REQUIREMENTS

Verification of the following factors unique to DAC eligibility is required prior to authorizing DAC MA eligibility:

- Receipt of SSI on the basis of blindness or a disability.
- Termination of SSI on or after July 1, 1987 because of entitlement to DAC RSDI benefits or an increase in such benefits.

Verification of receipt of DAC RSDI benefits under section 202(d) of the Act is required prior to authorizing DAC MA eligibility and at redetermination.

Verification policies for other eligibility factors are in the appropriate manual items.

Verification Sources

Receipt of SSI on the basis of blindness or a disability.

- Memo or other communication from central office.
- SSI letter (see **EXHIBIT II**).
- Social Security Administration.

Termination of SSI on or after July 1, 1987 because of entitlement to DAC RSDI benefits or an increase in such benefits:

- Memo or other communication from central office.
- SSI letter (see EXHIBIT II).
- Social Security Administration.

DEPARTMENT POLICY

All Programs

SSN refers to a Social Security Number.

SSA refers to the Social Security Administration.

As a condition of eligibility, clients, including persons being added to an active case, must:

- Supply their SSN.
- Cooperate in obtaining an SSN.
- Be excused from supplying and obtaining an SSN. See "EXCUSED FROM PROVIDING AND OBTAINING AN SSN".
- ~~Safe Delivery Babies.~~

Note: This condition of eligibility does **not** apply to persons who are only applying for benefits on behalf of someone else (example, parents who want MA just for their children).

Exception: For **FAP only**, expedited service recipients must cooperate in providing or obtaining an SSN before the first issuance **after** the expedited benefit.

Exception: For **CDC only**, obtain the social security number (SSN) of the CDC grantee. Do **not** deny eligibility solely because you are unable to obtain the SSN. **Note:** Day Care Aides and Relative Care Providers **must** provide verification of their SSN prior to their enrollment as a child care provider. (See PEM 704, CDC Providers).

Verification of an SSN is **not** initially required. Therefore, do **not** delay processing an application for verification of an SSN.

SSNs are checked with SSA for accuracy. If SSA is unable to confirm the SSN, you will receive an ASSIST enumeration alert and/or the PC-142 Report (see "Enumeration Alerts" and "PC-142 Report" in this item). The client must cooperate in resolving any errors.

FAILURE TO COMPLY

All Programs Except CDC

Disqualify family members for whom the client **refuses** to supply an SSN, cooperate in obtaining an SSN or cooperate in resolving any errors.

Note: Providing an SSN is **not** a condition of eligibility for CDC clients.

Note: Inform clients who provide an SSA-5028 or proof of Enumeration at Birth that they must report the SSN upon receipt. SSNs issued through these processes are **not** tape matched onto ASSIST. Failure to report these SSNs within 6 months of receipt or by the next redetermination, if earlier, results in an overissuance.

EXCUSED FROM PROVIDING AND OBTAINING AN SSN

All Programs

A person excused by court order is excused from providing and obtaining an SSN. ASSIST displays "Q" in the person's SSA Response field on the DEMOSS screen.

MA Only

The following persons are excused from providing and obtaining an SSN:

- Newborns automatically eligible per PEM 145.
- Deceased persons.
- Department wards or Title IV-E recipients (i.e., specialists are **not** responsible for enumeration for MA).
- Safe Delivery Babies

MA and AMP Only

The following aliens whose medical coverage is limited to emergency services are excused from providing and obtaining an SSN:

- Illegally present in the U.S.
- Nonimmigrant status (e.g., alien with a student visa).

  Note: This does **not** include parolees, permanent residents and other legal aliens whose medical coverage is limited to emergency services. See PEM 225.

APPLYING FOR A SOCIAL SECURITY CARD VIA SS-5

All Programs

A client meets the requirement of applying for an SSN by completing an SS-5, Application for a Social Security Card, at the local office. **You must help the client complete the form and the client must sign it.** See Reference Forms & Publications (RFF) SS-5 instructions.

Assist and advise the client, as needed, to provide verification of age, identity and citizenship/alien status required by SSA. Inform the client that SSA determines whether the submitted documents are acceptable. See the verification requirements on the SS-5.

NON-SALABLE ASSETS

SSI-Related MA Non-Salable Assets

SSI-Related MA Only

Give the asset a $0 countable value when it has no current market value as shown by one of the following:

- Two knowledgeable, appropriate sources (example: realtor, banker, stock broker) in the owner's geographic area state that the asset is **not** salable due to a specific condition. This applies to any assets listed under:
  - "INVESTMENTS".
  - "VEHICLES".
  - "LIVESTOCK".
  - "Burial Space Defined".
  - "EMPLOYMENT AND TRAINING ASSETS".
  - HOMES AND REAL PROPERTY (See below)
- In addition, for homes, life leases, land contracts, mortgages, and any other real property, an actual sale attempt at or below fair market value in the owner's geographic area results in no reasonable offer to purchase. The asset becomes salable when a reasonable offer is received. Count an asset that no longer meets these conditions.For applicants, an active attempt to sell must have started at least three months prior to application and must continue until the property is sold. For recipients, the asset must have been up for active sale at least 30 days prior to redetermination and must continue until the property is sold. An "Active Attempt to Sell" means the seller has a set price for fair market value, is actively advertising the sale in publications such as local newspapers, and or is currently listed with a licensed realtor.

CASH

FIP, SDA, LIF, G2U, G2C, SSI-Related MA and AMP

This section is about the following types of assets:

- Money/currency.
- Uncashed checks, drafts and warrants.
- Checking and draft accounts.
- Savings and share accounts.
- Money market accounts.
- LTC patient trust fund.

Referrals to Medicaid Eligibility Policy Section

Send all trusts and annuities to Medicaid Eligibility Policy Section for evaluation. Your referral must be in writing and include the following information:

- Your name, telephone number and local office.
- Client's name.
- Grantor's relationship to the client.
- Source of the assets used to establish the trust (example: money from client's lawsuit settlement, client's savings).
- Legible copies of the complete trust document, any amendments or addenda to the trust, correspondence, and similar information.
- Legible copies of all documents transferring ownership of property to the trustee.
- Relationship to the client of persons who transferred resources to trustee (example: client's parent, client's guardian).

Send referrals to:

Michigan Department of Human Services
~~State Office Building~~
~~305 Ludington Street~~
~~Escanaba, MI 49829~~
Attn: Trusts and Annuities
P.O. Box 30037
Suite 1307
Lansing, MI 48909

Advice is only available to local offices and only for purposes of determining eligibility when a trust actually exists. Advice is **not** available for purposes of estate planning, including advice on proposed trusts or proposed trust amendments.

HOME CARETAKER AND PERSONAL CARE CONTRACTS

A contract that prospectively pays for expenses such as repairs, maintenance, property taxes, homeowner's insurance, heat and utilities for real property/homestead or that provide for monitoring health care, securing hospitalization, medical treatment, visitation, entertainment, travel and/or transportation, financial management or shopping, etc. would be considered a divestment. Consider all payments for care and services which the client made during the "look back period" as divestment. Refer to PEM 405.

Limited Liability Corporations (LLCs)

SSI-Related MA Only

Count assets in a Limited Liability Corporation (LLC).

LIVESTOCK

SSI-Related MA Only

Exclude farm animals used for personal consumption. Exclude family pets.

Other livestock might be excluded as an employment asset. See "EMPLOYMENT ASSET EXCLUSIONS" in this item.

EMPLOYMENT AND TRAINING ASSETS

SSI-Related MA Only

Employment assets are those assets commonly used in a business, a trade or other employment. Examples:

- Farmland.
- Tools, equipment and machinery.
- Inventory, livestock.
- Savings or checking account used solely for a business.
- The building a business is located in.
- Vehicles used in business such as a farm tractor or delivery truck. It does **not** include vehicles used solely for transportation to and from work.

Such assets might also be used in education or job training.

Employment or Training Asset Value

SSI-Related MA Only

See the appropriate sections above regarding the value of vehicles, real property and savings or checking accounts. The value of other employment or training assets is their equity value. Equity value is fair market value minus the amount legally owed in a written lien provision.

Payment-In-Kind (PIK) Program

SSI-Related MA Only

A PIK commodity or commodity certificate may be an asset. See PEM 500, "PAYMENT-IN-KIND (PIK) PROGRAM".

EMPLOYMENT ASSET EXCLUSIONS

General Employment Exclusion

SSI-Related MA Only

Exclude employment assets (see above) that:

- Are required by a person's employer, or
- Produce income directly through their use.

- Any person (including a court or administrative body) acting at the direction or upon the request of the client or his spouse.

TRANSFER OF A RESOURCE

Transferring a resource means giving up all or partial ownership in (or rights to) a resource. **Not** all transfers are divestment. Examples of transfers include:

- Selling an asset for fair market value (not divestment).
- Giving an asset away (divestment).
- Refusing an inheritance (divestment).
- Payments from a **"MEDICAID TRUST"** that are **not** to, or for the benefit of, the person or his spouse. See PEM 401 (divestment).
- Putting assets or income in a trust. See PEM 401.
- Giving up the **right** to receive income such as having pension payments made to someone else (divestment).
- Giving away a lump sum or accumulated benefit (divestment).
- Buying an annuity that is **not** actuarially sound (divestment).
- Giving away a vehicle (divestment).
- Putting assets or income in an LLC (Limited Liability Corporation)

Also see "Joint Owners and Transfers" for examples.

Transfers to an LLC

Treat transfers to an LLC (Limited Liability Corporation) as a divestment unless the client retains all rights to the asset or income invested and may withdraw the asset invested on demand.

Treat transfers to an LLC that has no discernible product (goods and or service) produced as a divestment.

Transfers by Representatives

Treat transfers by any of the following as transfers by the client or spouse.

- Parent for minor.
- Legal guardian.
- Conservator.
- Court or administrative body.
- Anyone acting in place of, on behalf of, at the request of or at the direction of the client or spouse.

chase was 15.72 years while the guarantee period ends in 20 years (five year delay plus 15 years).

Example: Diane purchased an annuity at age 65 with a guarantee period of 25 years. The annuity is not actuarially sound because Diane's life expectancy is only 19.50 years.

The amount transferred for less than fair market value for an annuity that is **not** actuarially sound is the amount that would be paid after the end of the person's life expectancy.

Example: Diane purchased an annuity at age 65 with a guarantee period of 25 years. The annuity is **not** actuarially sound because Diane's life expectancy is only 19.50 years. The amount transferred for less than fair market value is the value of the payments due in the last 5.5 years of the annuity (25 minus 19.50 = 5.50).

Example: Sally purchased an annuity at age 70 with a guarantee period of 15 years and payments starting five years after purchase. The annuity is **not** actuarially sound because Sally's life expectancy at purchase was 15.72 years while the guarantee period ends in 20 years. The amount transferred for less than fair market value is the value of the payments due in the last 4.28 years of the annuity (20 - 15.72 = 4.28).

LOOK-BACK PERIOD

The first step in determining the period of time that transfers can be looked at for divestment is determining the **baseline date**. See "Baseline Date" below.

Once you have determined the baseline date, you determine the look-back period. The look back period is 60 months prior to the baseline date for all transfers made after February 8, 2006 and 36 or 60 months (depending on the type of resource transferred) prior to the baseline date for transfers made on or before February 8, 2006. See "Medicaid Trusts" PEM 401.

Entire Period

Transfers that occur **on** or **after** a client's baseline date must be considered for divestment. In addition, transfers that occurred within the 60 month look-back period must be considered for divestment.

Penalty Situation

A divestment determination is **not** required unless, sometime during the month being tested, the client was in a penalty situation. To be in a penalty situation, the client must be eligible for MA (other than QDWI) and be one of the following:

- In an LTC facility.
- "APPROVED FOR THE WAIVER" (PEM 106).
- Eligible for Home Help.

The 1st day the client is eligible to receive MA coverage for LTC, MIChoice, home help, or home health services is the 1st day after the penalty period ends.

Baseline Date In Calendar Year	LTC Cost
2009	$6362
2008	$6191
2007	$5938
2006	$5549
2005	$5367
2004	$5250
2003	$5043
2002	$4703
2001	$4518
2000	$4331
1999	$3981
1998	$3711
1997	$3507
Before January 1997	$3441

The penalty period starts on the date which the individual is eligible for Medicaid and would otherwise be receiving institutional level care (LTC, MIChoice waiver, or home help or home health services), and is not already part of a penalty period. If a penalty is determined for an unreported tranfer in the past, apply the penalty from the first day after timely notice is given. See "Recipient Exception" below.

Recipient Exception

Timely notice must be given to LTC recipients and (PEM 106) waiver recipients before actually applying the penalty. Adequate notice must be given to new applicants.

Uncompensated Value

The uncompensated value of a divested resource is

- The resource's cash or equity value.
- Minus any compensation received.
- The uncompensated value of a promissory note, loan, or mortgage is the outstanding balance due on the "Baseline Date"

Spouses Sharing a Penalty

A client can be penalized if he or his spouse divests. The penalty is imposed on whichever spouse is in a "Penalty Situation." If both spouses are in a penalty situation, the penalty period (or any remaining part) must be divided between them.

- are **not** eligible for any other MA category.

Example: The TMA-Plus group meets all the TMA-Plus eligibility requirements. The adults in the TMA-Plus group are **not** MA eligible, but the children in the TMA-Plus group are Healthy Kids eligible. The TMA-Plus qualified group is the adults.

The TMA-Plus qualified group is TMA-Plus eligible when the initial premium payment is paid by the due date. See **"Initial Premium Payment."**

Note: The group decides whether to pay the premium for all the qualified group members or only some members. However, if someone's premium is not paid, they **cannot** re-enroll in TMA-Plus unless the group member is once again TMA eligible.

ONGOING ELIGIBILITY

During each 12-month period between redeterminations, eligibility continues unless:

- Premiums are **not** paid on or before the due date (see **"PREMIUM PAYMENTS"**).

  Note: A TMA-Plus eligible group member may choose to end his/her eligibility without affecting the eligibility of other members.

- Payment received is less than the full premium amount or considered to be "non-sufficient funds" (NSF).

- The TMA-Plus group no longer contains a child who meets age and school attendance requirement.

- Other comprehensive health insurance is obtained or is available from an employer for the same or less than the TMA-Plus premium amount.

- Residence/institutional status factors in **"NONFINANCIAL ELIGIBILITY FACTORS"** are no longer met by a TMA-Plus eligible group member.

- A TMA-Plus eligible group or group member is approved for an MA category including FIP. A pregnant woman must be transferred to Healthy Kids for Pregnant Women (HKP). She may regain her TMA-Plus eligibility after the pregnancy ends.

A group member who loses TMA-Plus eligibility **cannot** re-enroll in TMA-Plus unless the group member is once again TMA eligible.

Ongoing Financial Eligibility

Financial eligibility is only considered at initial eligibility and at annual redetermination. Income and income limit changes are **not** considered until the next redetermination.

Continuity of Coverage

The intent is that there be **no** break in coverage between when TMA ends and TMA-Plus begins. TMA-Plus must begin the first day of the month following TMA.

If TMA continues beyond the 12-month period, (for example, the TMA group requests an administrative hearing):

- TMA-Plus coverage will be authorized retroactively if the initial premium payment is paid by the due date, or
- TMA-Plus coverage will **not** be authorized retroactively if the initial premium payment is **not** paid by the due date.

PREMIUM PAYMENTS

The monthly premium payment changes at 12, 18, and 24 months. ~~every six months for two years.~~ After two years the premium remains constant.

The following are monthly TMA-Plus premiums:

- ~~**1st six months**~~ $50.00 per person for the first year.
- ~~**2nd six months**~~ ~~$55.00~~$83.00 per person for the next six months.
- ~~**3rd six months - $83.00 per person**~~
- ~~**4th six months or later**~~ $110.00 per person thereafter.

Initial Premium Payment

You **must** send the DHS-1075, TMA-Plus Eligibility Notice, to the qualified TMA-Plus group at least 40 calendar days before the last day of TMA. This allows:

- the TMA-Plus group time to pay the initial premium payment, and
- DCH time to activate TMA-Plus eligibility.

The initial premium payment must be U.S. postmarked **not** more than 30 days after the date that the DHS-1075 is sent to the TMA-Plus group notifying them that they qualify for TMA-Plus.

Subsequent Premium Payments

Subsequent premium payments must be paid in full and received by DCH on or before the first day of the month. ~~U.S. postmarked on or before the first day of each month.~~

LOCAL DHS RESPONSIBILITIES

The administration and implementation of the TMA-Plus program is a joint effort between the DHS and DCH. This section describes local DHS responsibilities.

Redetermination (TMA Ends)

A determination of continuing MA eligibility **must** be completed at least 40 days before the last day of the 12-month TMA period (see PEM 111 and 645). See **"Initial Premium Payment."**

The RD-210, TMA Redetermination Report, will first identify TMA cases in the fourth month before the end of TMA eligibility. For example, a TMA case whose TMA ends in September 2009 will first be listed on the report in the month of June 2009.

You must begin redetermination procedures immediately so that all DHS actions are completed at least 40 days before the end of the 12-month TMA eligibility period.

Follow normal redetermination procedures in PAM 210 except for the following:

- Send MSA Publication 213, TMA-Plus, along with the DHS-1171, Assistance Application.
- The due date for return of the DHS-1171 and verifications is the CIMS negative action effective date in RFS 103 which corresponds to the processing date.
- If the application and/or verifications are returned incomplete, you **must** allow the group additional time to complete the application and/or obtain verifications. The due date is the negative action effective date in RFS 103 which corresponds to the processing date.

Most children are eligible under Healthy Kids (PEM 129, 131). If the children are not Healthy Kids eligible due to income, use an DHS-45, DHS to DCH/MIChild/FTW Transmittal and send legible photocopies of the following to MIChild via U.S. mail at the address below:

- The DHS-1171.
- The Healthy Kids budget sheet.
- Any other Healthy Kids-related eligibility information.
- Any Healthy Kids-related verifications.

MIChild
PO Box 30412
Lansing, MI 48909

No MA or TMA-Plus Eligibility

If the adults (including children age 19) in the TMA group are not eligible for other MA categories or TMA-Plus (for example, the family did not return the DHS-1171), follow normal procedures in PAM 220 **except** you must enter the last day of the TMA redetermination month as the negative action date.

All TMA Group Members MA Eligible

If all members of the TMA group are eligible for other MA categories, proceed as follows:

- LIF eligible -
  - Change Eligibility Status (ES) to 6, and
  - Change Scope/Coverage (SC) 1T to 1F and 1V to 1E effective the next month. Do not change scope/coverage if it is already 1F or 1E.
- Eligible for other MA categories (not deductible) - follow normal procedures **except** the MA begin date for the other MA categories is the first day of the month after the 12-month TMA period.

Qualify for TMA-Plus

If the adults qualify for TMA-Plus, proceed as follows:

- Send the DHS-1075, TMA-Plus Eligibility Notice, and one MSA-652-TMA payment envelope to the family. The DHS-1075 advises the group that:
  - Ongoing MA eligibility is being terminated.
  - The group **qualifies** for TMA-Plus.
  - The amount of the initial premium payment.
  - The due date for the initial premium payment.
  - The consequences if the initial premium payment is not paid timely.
- Forward a copy of the DHS-1075, TMA-Plus Eligibility Notice, to DCH at the address below. You may also email the DHS-1075, TMA-Plus Eligibility Notice, to TMA-Plus@michigan.gov.

This will give DCH notice that the group qualifies for TMA-Plus and the due date of the initial premium payment.

Note: ~~Notify the TMA-Plus coordinator when the family receives TMA prior to the termination of program C in the case of EFIP~~. CIMS will not indicate receipt of TMA if the family receives EFIP. It is the responsibility of the specialist to explain this when referring a previous EFIP recipient to TMA-Plus.

Notify the TMA-Plus coordinator at DCH with ~~Enter~~ a notation in red indicating the number of months the family received ~~TMA~~LIF but counted as TMA as part of EFIP eligibility, includ~~eing the~~ dates.

Department of Community Health
TMA-Plus Coordinator
PO Box 30656
Lansing, MI 48909-9635

DCH RESPONSIBILITIES

The administration and implementation of the TMA-Plus program is a joint effort between the DHS and DCH. This section describes DCH responsibilities.

DCH is responsible for monitoring the initial and subsequent premium payments from the TMA-Plus group.

Initial Premium Payment Collection

DCH is responsible for monitoring that the initial TMA-Plus premium payment is paid by the due date. If the initial premium payment is paid by the due date, DCH will:

- delete the pending negative action (the TMA transfer to deductible), and
- change TMA to TMA-Plus on CIMS effective the day after TMA eligibility ends, and
- send you an DHS-1076 as notice of TMA-Plus eligibility.

DCH will not take any action if payment was not made by the due date. The case will become an active deductible.

Subsequent Premium Payment Collection

DCH is responsible for monitoring that each subsequent premium payment is received~~postmarked~~ by the first of each month and is the correct premium amount.

If the payment is not received~~postmarked~~ by the first of the month or if the payment received is for an amount less than the premium amount, DCH will:

- Send the TMA-Plus group an MSA-710 with the CIMS negative action effective date as the closure date.
- Enter a negative action code on CIMS with the computed negative action date prefixed with an "N".

If the premium payment is received DCH will:

- Delete the pending negative action if the premium payment is received prior to the negative action effective date.
- Reinstate the TMA-Plus if the correct premium payment is received after the negative action effective date, but with a postmark prior to the negative action effective date.
- Send you an DHS-1076 as notice of:
  - reinstatement so that you can send an DHS-1074 to the TMA-Plus group, or

- TMA-Plus closure if premium is not paid.

Note: DCH will refund premium payments postmarked after the closure date.

Other Insurance Codes

DCH checks CIMS monthly for Other Insurance (OI) codes. If the Third Party Liability~~Revenue and Reimbursement~~ Division in DCH adds an OI code to CIMS for a TMA-Plus recipient, DCH sends an MSA-710 to the TMA-Plus group requesting other insurance information. If the other insurance premium is less than the TMA-Plus premium, DCH initiates closure of TMA-Plus and notifies you of this on the DHS-1076 after the effective date of case closure.

REPORTING RESPONSIBILITIES

The TMA-Plus group must report certain changes within 10 days of the change. Such changes are:

- Address.
- .Family composition.
- A child in the family age 18 or 19 is no longer a full-time high school student.
- Availability of comprehensive health insurance coverage.
- Cost of comprehensive health insurance coverage.

HEARING RIGHTS

See PAM 600 for DHS/DCH responsibilities when a hearing is requested regarding TMA-Plus eligibility or payment of premiums.

INSTRUCTIONS

When a group initially qualifies for TMA-Plus, DHS does not enter TMA-Plus coding on CIMS. DCH updates the data elements to input TMA-Plus on CIMS once a qualified group pays the initial premium.

See How Do I for coding information.

LEGAL BASE

DCH Appropriations Act

DEPARTMENT POLICY

Maternity Outpatient Medical Services (MOMS) is a health coverage program operated by the Department of Community Health (DCH). MOMS provides prenatal and postpartum outpatient pregnancy-related services to women who are pregnant or recently pregnant and who are not eligible for Medicaid (see **"TARGETED POPULATION"** below).

MOMS is not a Medicaid program.

COVERAGE PERIOD

The MOMS coverage period is from the date of application, with a maximum of 45 days of coverage unless the individual receives Medicaid ESO eligibility.

Medicaid ESO beneficiaries~~eligible women~~ receive prenatal care ~~for the entire pregnancy~~ and medically necessary ambulatory postpartum care for 60 days after the pregnancy ends regardless of the reason.

TARGETED POPULATION

Women who are pregnant or within two calendar months following the month pregnancy ended and are:

- Eligible for Medicaid emergency services only, or
- Applicants for Medicaid whose income, after deductions, appears to be at or below 185% of poverty, but whose eligibility has not yet been determined.

APPLICATION FOR MOMS

Local health departments, federally qualified health centers, and other trained providers assist pregnant women with applications for MOMS by:

- Assisting the woman over the telephone and making appointments with eligible/interested women.
- Advising the applicant of any verification requirements and assisting in securing any required documentation.
- Completing or assisting in the completion of the MSA-1142, MOMS Enrollment Notice.
- Completing the DCH-1164, Guarantee of Payment for Pregnancy-Related Services.
- Submitting the MOMS application materials, including a copy of the MSA-1142 and DCH-1164 to DCH.

Exception: The following pregnant women may be enrolled directly into the MOMS program without a financial determination: